



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ANESTHESIA ALLIANCE OF DALLAS PA
SUITE 202
4275 LITTLE ROAD
ARLINGTON TX 76016

Respondent Name

AMERICAN CASUALTY CO OF READING

Carrier's Austin Representative

Box Number 47

MFDR Tracking Number

M4-12-2896

MFDR Date Received

May 14, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has denied payment of Code 01480 AA stating that the 'non-covered services because this is not deemed a medical necessity by the payer.' This denial is incorrect. We obtained a copy of the authorization letter which clearly states 'determined this specific medical service meets established criteria for medical necessity and appropriateness.'"

Amount in Dispute: \$665.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is billing for anesthesia lower leg bone surgery (CPT Code 01480). At the same time, however, the provider billed for anesthesia [sic] generally [sic]. The additional anesthesia [sic] was not part of the pre-authorized ankle arthroscopy/surgery (CPT Code 29898) or partial removal of ankle/heel (CPT Code 28120). Therefore, the carrier denied reimbursement for CPT Code 01480 asserting that this was a duplicate service and this service was not medically necessary since this service was not pre-authorized and subject to retrospective review. The carrier relies upon its review and reduction not the provider's bill as reflected in its EOBs. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 19, 2011	01480-AA	\$665.39	\$665.39

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 50 – These are non-covered service because this is not deemed a medical necessity by the payer. Service denied. Please contact the SRS Claims Examiner regarding these charges.
- Note: This procedure on this date was previously reviewed
- 18 – Duplicate claim/service

Issues

1. Did the requestor obtain preauthorization for the disputed service?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 “(p) Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section.”

Preauthorization was obtained for right ankle arthroscopy with debridement; excision of ostrigum rt ankle, with a start date of October 13, 2011 and an end date of November 30, 2011. The disputed CPT code, 01480 was rendered on October 19, 2011.

The requestor billed CPT code 01480 defined as “Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified.” The requestor billed for anesthesia (CPT code 01480) for a preauthorized surgical procedure, therefore, the insurance carrier’s denial of unnecessary medical is unsupported and the disputed service will be reviewed pursuant to 28 Texas Administrative Code §134.203.

2. 28 Texas Administrative Code §134.203(a)(5) states “Medicare payment policies” when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

28 Texas Administrative Code §134.203(b)(1) states “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers’ compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

A review of the submitted medical bill finds that the requestor appended modifier AA to CPT code 01480. CPT code 01480 is defined as “Anesthesia for open procedures on bones of lower leg, ankle, and foot; not otherwise specified,” and appended modifier AA is defined as “anesthesia services performed personally by anesthesiologist.”

3. Per 28 Texas Administrative Code §134.203 (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year’s conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year’s conversion factors, and shall be effective January 1st of the new calendar year.”

The Division reviewed the submitted CMS-1500 (bill) and finds that the anesthesia was started at 0732 and ended at 0951, for a total time of 138 minutes.

Per CMS one anesthesia time unit = 15 minutes of anesthesia time. The 15-minute time interval will be divided into the total time indicated on the claim. Total time should always be accurately reported in minutes. Actual time units will be paid; no rounding will be done up to the next whole number – only round to the next tenth. Therefore, the requestor has supported $138/15 = 9.2$.

To determine the MAR the following formula is used: (Time units + Base Units) X Conversion Factor = Allowance.

The Anesthesia Base Units for CPT code 01480 is 03; the 2011 DWC Conversion Factor is \$54.54.

The MAR for CPT code 01480-AA is: (Base Unit of 3 + Time Unit of 9.2) X \$54.54 DWC conversion factor = \$665.39. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$665.39.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$665.39 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	<u>October 17, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.